NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHERIDAN FAMILY DENTSITRY
1895 SHERIDAN DRIVE
BUFFALO, NY 14223

I understand that, under the Health Insurance Portability & Accountability Act of 1986 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers may be involved in that treatment directly and indirectly.
- Obtain payment from third-party certifications.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

PRINT NAME

_____ _____

SIGNATURE **DATE**